LTC Residents Protection
JUL 16 2010
Director's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085042	A. BUILDING _____ B. WING _____	C 06/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. FRANCIS CARE/BRACKENVILLE	100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from June 1, 2010 through June 15, 2010. The deficiencies contained in this report are based on observations, staff interviews, review of clinical records, facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was eighty seven (87). The survey sample totaled fifty-seven (57) residents.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	1. The family of Resident 177 was notified on 5/26/10 of the change in Zoloft and the psychological evaluation. 2. Residents who have a change in condition or medication and those residents who participate in a psychological evaluation are impacted by this practice. 3. The policy and procedure for notification of change in condition has been reviewed by the Director of Nursing (DON) and clarification hs been made regarding what actually requires family and/or physician notification to better assist licensed personnel in Licensed Nursing personnel will be educated on the Notification of Change in Condition. An audit will be conducted to randomly check 20 charts per month for 3 months than 10/month for the next 3 months. This audit will be conducted by the RNAC and/or designee. 4. The results of the monitoring and recommendations will be submitted to the QI Committee for 6 months by the RNAC. Recommendations of the QI Committee will be followed.	8/17/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michele Young — TITLE: Administrator — (X6) DATE: 7/8/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to notify the family of changes in medication for 1 (R177) out of 57 Stage II sampled residents. Findings include: R177 was admitted to the facility on 1/22/10 with diagnoses including Alzheimer's Disease and depression. R177 had been on a medication, Zoloft 100 mg. for depression daily. On 5/13/10, a psychological consultation was done which recommended and ordered decreasing Zoloft to 75 mg daily. On 5/14/10, R177 began on the lower dose of Zoloft. Review of R177's physician's order, dated 5/13/10, revealed that it was blank in the area of family notification. Review of the Nurses Notes (NN) for that timeframe lacked evidence of family notification. On 6/8/10, in an interview with E2 (Director of Nursing), she stated that R177 had increased aggressive behavior when Zoloft was reduced. E2 stated that family was very involved and had cared for R177 at home prior to admission to the facility. E2 also stated that the family felt that the Zoloft helped with his aggressive behavior. R177's physician increased Zoloft to 100 mg on	F 157		

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F 157	Continued From page 2 5/26/10. On 6/8/10, E2 and E7 (LPN Unit Manager) acknowledged that the facility failed to notify the family of the change of medication dosage.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was	F 164	1. The Director of Nursing immediately educated the Nurse Practitioner regarding personal privacy as soon as notified of the incident. The physician responsible for the resident was also notified. Resident R57 is provided with personal privacy. 2. Any resident in the facility is entitled to personal privacy. 3. Physicians and physician groups have been provided with information regarding personal privacy. Facility personnel have been in-serviced regarding personal privacy for the residents. A monitor will be developed to randomly observe two physicians/nurse practitioners/week by the Unit Manager and/or designee. This monitor will be completed for a period of 6 months. 4. The results of the monitoring and recommendations will be presented to the QI Committee by the DON/designee. The recommendations of the QI Committee will be followed.	8/17/10

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F 164	Continued From page 3 determined that the facility failed to ensure that 1 (R57) out of 57 Stage II sampled residents were provided with personal privacy. Findings include: On 6/8/10 at 6:30 PM, during a dining observation of the facility, R57 was being fed by E14 (LPN) in the dining room/lounge on the 400 unit with other residents present. While R57 was eating, the Nurse Practitioner (NP) was observed entering the dining room and examined R57, listening to her heart with a stethoscope. The facility failed to ensure R57's privacy during a medical examination. On 6/8/10, E2 (Director of Nursing/DON) was informed of the observation and stated that she would speak with the NP.	F 164	1. Resident R204 now has a phone in her room which she can use when desired.	8/17/10
F 174 SS=D	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide phone privacy for 1 (R204) out of 57 Stage II sampled residents. Findings include: On 6/7/10 in the afternoon, R204 was observed asking to use the telephone. She was pushed in the wheelchair to the nurses' station and staff dialed the phone number for her. On 6/8/10 between 10:30 and 11:30 AM, R204 was observed using the phone at the nurses' station, once with E1 (Administrator) assisting and once with E7 (LPN Unit Manager) assisting.	F 174	2. Any residents desiring the use of a telephone is impacted by the right for privacy during phone calls. 3. Facility staff has been in-serviced pertaining to the right to privacy during phone conversations for residents. To be included in the in-service is the availability of facility cell phones and areas/rooms for residents desiring to use a telephone. The Unit Manager and/or designee will monitor resident telephone requests for 6 months to ensure privacy is provided. Results will be provided to the Director of Social Services/designee for review and recommendations. 4. The Director of Social Services will present the results of the monitoring and the recommendations to the QI Committee. The recommendations of the QI Committee will be followed.	

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F 174	Continued From page 4 On 6/8/10, during an interview with E7, he stated that residents who do not have phones or cell phones in their rooms use the phone at the nurses' station. On 6/8/10 in an interview with E1, she stated that the facility has 2 mobile phones as well as the board/conference room that can be used for residents to ensure privacy when using the phone. E1 stated that R204 just moved to her current room. The facility failed to provide phone privacy for R204.	~~F 174~~		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	1. Incident reports for Resident R133 and Resident R137 dated 5/28/10 and 4/30/10 respectively have been submitted to Delaware Division of Long Term Care Residents Protection. 2. Any incident report involving a resident in the facility is required to have timely submission to the appropriate agencies. 3. The DON has been in-serviced by a contracted RN Consultant from Zimmett Healthcare Services (contracted to provide guidance to facility nursing administration) regarding timely reporting of mistreatment, neglect or abuse, incidents of unknown origin and misappropriation of resident property. This in-service included reporting to the Administrator and to other officials in accordance with State Law through established procedure. Facility personnel have	8/17/10

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F 225	Continued From page 5 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and review of facility policies and procedures and other documentation, it was determined that the facility failed to ensure that two (R133 and R137) out of three sampled residents allegations of abuse/neglect were immediately reported to the State Agency. Findings include: 1. Review of a facility incident report, dated 5/28/10, revealed that on 5/19/10, R133 alleged that a Certified Nursing Assistant (CNA) was unwilling to take care of him during PM care due to his medical condition. The facility investigated the incident, determined that the allegation did occur and called it a miscommunication between R133 and the CNA. The facility failed to immediately report the incident to the State Agency. It was not reported until 5/28/10, 8 days later.	F 225	been in-serviced regarding the timely reporting of mistreatment, neglect or abuse, incidents of unknown origin and misappropriation of resident property. An audit tool has been developed that tracks each reportable incident from the time of staff knowledge to the submission of the 5 day report to ensure that the facility submits the incident reports to the Delaware LTCRP per facility policy and State and Federal regulations. This tracking will be maintained by the Administrator for review of 100% of the reportable incidents for 3 months and 50% for the next 3 months to ensure reportable incidents are reported per facility policy. This tracking will be conducted by the Administrator/designee. 4. The Administrator will present the results of the monitoring and the recommendations to the QI Committee. The recommendations of the QI Committee will be followed.	

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F 225	Continued From page 6 2. Review of a facility incident report, dated 4/30/10, revealed that on 4/25/10 staff reported to management that R137 was physically and verbally abused by a family member. The facility investigated the incident, determined that the allegation did occur and subsequently established supervised visits with the family member. Facility documents revealed that this incident of family to resident abuse was not reported to the State Agency until 4/30/10, 5 days later. The facility reported the incident to the Adult Protective agency on 4/28/10. The facility procedure entitled Reporting of Resident Abuse ... " , Section "Visitor to Resident Abuse" , it stated that this type of incident needed to be reported to the state agency immediately via fax. Findings were confirmed with E2 (Director of Nursing) on 6/7/10.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of employee records, policies and procedures, and staff interview, it was determined that the facility failed to implement their policies and procedures for screening employees that included a completed background investigation in a timely manner for two (E19 and E20) of three sampled therapists. E19 and E20 were missing the criminal background check and the child abuse checks. Additionally, the facility	F 226	1. E19 and E20 have criminal background checks and child abuse checks completed. Those employees of E22, E23, E24 and E25 who remain in employment have completed abuse training. 2. Residents are assured that facility employees have completed mandatory in-services and criminal background and child abuse checks have been completed. 3. A check list for mandatory prerequisites for employment is being utilized by the contract therapy company to include adult and child abuse checks, criminal background checks and drug screening. This information will be submitted to the	8/17/10

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F 226	Continued From page 7 failed to ensure that four (E22, E23, E24 and E25) of nine (9) staff sampled received abuse training on an annual basis. Findings include: The facility's policy and procedure regarding Abuse, "Employee Screening " was reviewed. The procedure stated that, "a minimum of two reference checks ...., a criminal background check, adult and child abuse check and drug screening are required before an offer of employment is extended " . 1. Review of the facility employee documents revealed that two of three contracted therapy staff, E19 (Occupational Therapist) hired on 2/22/10 and E20 (Certified Occupational Therapy Assistant) hired on 6/1/09 did not have federal or state criminal background records and child abuse checks on file. On 6/08/10, an interview with E21 (Human Resource Manager) revealed that the reviews were not completed until 6/8/10. 2. Four (E22, E23, E24 and E25) of nine (9) staff lacked evidence that they received abuse training upon hire or on their anniversary date. The facility's policy and procedure regarding Abuse, "Employee Training " was reviewed. The procedure stated that, "All employees must attend the facility's orientation program prior to assignments in the clinical areas. The orientation program included the review of the facility's Policy and Procedure on Abuse, Neglect, Mistreatment, Serious Injury, Misappropriation of property, and Injury of Unknown Origin, ... Quarterly and more frequent as needed; the facility employees are in-serviced on the "Abuse" policy and procedure during their orientation program and as needed. Agency personnel are in serviced on the "Abuse"	F 226	Human Resource Manager/designee prior to the therapist working in the facility. All new employees will be in-serviced on abuse during orientation as well as on an annual basis by the Staff Development Coordinator/designee. Staff Development Coordinator/designee will maintain a complete record of the in-services attended by personnel. A quarterly audit will be conducted for 6 months by the Human Resource Manager/designee to ensure that Orientation and annual in-services include abuse training. A monthly audit for 6 months will be conducted by the Human Resource Manager of all full and part time therapists to ensure compliance with prerequisites for employment. 4. The Human Resource Manager will present the results of both audits and the recommendations to the QI Committee. The recommendations of the QI Committee will be followed.	

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F 226	Continued From page 8 policy and procedure during their orientation program and as needed ". Review of employee files indicated that E22 (CNA) was hired on 5/1/10. There was no evidence that E22 had received abuse training upon hire. Review of employee files indicated that E23 (RN) was hired on 3/12/09. There was no evidence that E23 had received abuse training upon hire. Review of employee files indicated that E24 (LPN) was hired on 9/8/08. There was no evidence that E24 had received abuse training upon hire or annually. Review of employee files indicated that E25 (LPN) was hired on 4/10/06. There was no evidence that E25 had received abuse training upon hire or annually. Interview with E5 (Staff Development Nurse) on 6/11/10 revealed that Abuse training was required yearly for all staff and she confirmed these findings. Additionally, interview with E21 (Human Resource Manager) on 6/14/10 confirmed these findings.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241	1. Residents R2, R4, R20,R32, R34, R43, R57, R76, R79, R95, R136, R139 and R213 are asked for preference to use a cloth protector prior to meals. R4 is provided with meals at the same time as the residents at the same table. Residents R57, R95, R136 and R213 are provided with regular silverware. 2. Residents who dine in the facility are impacted by being asked for their preference of using cloth protectors. Residents who dine at the same table are impacted by being ensured that they eat at the same time. Residents who dine at the	8/17/10

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F 241	Continued From page 9 Based upon observation and interview it was determined that the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect during the dining experience for 13 (R2, R4, R20, R32, R34, R43, R57, R76, R79, R95, R136, R139, and R213) out of 57 Stage II sampled residents. One (R4) of the 13 residents was seated at a table with 3 other residents who were being fed their meal while R4 waited more than 15 minutes before she was fed. Four (R57, R95, R136 and R213) of the 13 residents were not provided with silverware during an evening meal and instead received plastic utensils. Ten (R2, R20, R32, R34, R43, R57, R76, R79, R95, and R139) of the 13 residents were not asked if they desired a clothing protector before it was applied at meal time. Findings include: 1. On 6/8/10 at 5:45 PM during dinner, R4 was observed sitting at a table with three other residents who were being assisted (fed) with their meal. R4 had a covered plate and drinks in front of her, however was not receiving any assistance. At 6:03 PM, E9 (CNA) was observed sitting down next to R4 and quickly getting up to go to the kitchen. E9 was observed returning from the kitchen at 6:10 PM, then sat next to R4 again and started feeding the resident her meal. R4, a resident coded on the 4/17/10 quarterly MDS assessment as total dependence for eating, waited more than 15 minutes to be assisted with her meal while other residents at the table were eating. 2. On 6/8/10, during the evening meal, R57 was observed being fed with plastic utensils.	F 241	facility are impacted by the use of anything other than regular silverware, unless otherwise reflected in the individual care plan. 3. A policy and procedure has been developed by the Director of Nursing pertaining to the use of cloth protectors. An in-service has been conducted by the Staff Development Coordinator/designee for facility personnel pertaining to dining dignity to include use of cloth protectors and asking residents for their preference for such, ensuring residents dine at the same time at each table, and ensuring that the table is set with the proper utensils. An audit will be conducted by nursing supervisor/designee to randomly observe 10 meals/week for one week, 7 meals per week for 3 weeks, 5 meals per week for 2 months and 3 meals per week for three months to ensure that resident preferences for cloth protectors are respected, that residents are being provided with food at the same time for each table, and that silverware is used at the meals. Silverware has been ordered and received to ensure sufficient supplies are available for dining purposes. The Dietary Manager will audit weekly to ensure that sufficient utensils are available for usage throughout the	

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F 241	Continued From page 10 3. On 6/8/10, during the evening meal, R95 was observed being fed with plastic utensils. 4. On 6/8/10, during the evening meal, R136 was observed eating with plastic utensils. 5. On 6/8/10, during the evening meal, R213 was observed eating with plastic utensils. On 6/8/10, an interview with E6 (nurse) after the observation revealed that the kitchen had run out of clean silverware and had to substitute the plastic utensils. 6. On 6/7/10, prior to the onset of the midday meal, E11 (CNA) was observed applying a clothing protector on R34 without first asking if the resident wanted one. 7. On 6/7/10, prior to the onset of the midday meal, E11 (CNA) was observed applying a clothing protector on R43 without first asking if the resident wanted one. 8. On 6/7/10, prior to the onset of the midday meal, E11 (CNA) was observed applying a clothing protector on R76 without first asking if the resident wanted one. 9. On 6/8/10, prior to the onset of the dinner meal, E15 (CNA) was observed applying a clothing protector over R79's head from behind without first asking if the resident wanted one. On 6/8/10, in an interview after the dinner meal, E15 stated that he placed the clothing protector on R79 without asking if the resident wanted one. 10. On 6/8/10, prior to the onset of the dinner	F 241	day for 6 months. 4. The DON/designee will present the results of the dining audit and the recommendations to the QI Committee. The recommendations of the QI Committee will be followed. The Dietary Manager will present the results of the utensil audit and the recommendations to the QI Committee. The recommendations of the QI Committee will be followed.	

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F 241	Continued From page 11 meal, E15 (CNA) was observed applying a clothing protector over R139's head from behind without first asking if the resident wanted one. On 6/8/10, in an interview after the dinner meal, E15 stated that he placed the clothing protector on R139 without asking if the resident wanted one. 11. On 6/8/10, prior to the onset of dinner, E14 (LPN) was observed applying a clothing protector on R2 without first asking if the resident wanted one. 12. On 6/8/10, prior to the onset of dinner, E14 (LPN) was observed applying a clothing protector on R20 without first asking if the resident wanted one. 13. On 6/8/10, prior to the onset of dinner, E14 (LPN) was observed applying a clothing protector on R32 without first asking if the resident wanted one. 14. On 6/8/10, prior to the onset of dinner, E14 (LPN) was observed applying a clothing protector on R57 without first asking if the resident wanted one. 15. On 6/8/10, prior to the onset of dinner, E14 (LPN) was observed applying a clothing protector on R95 without first asking if the resident wanted one.	F 241		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	1. The following rooms have been cleaned and/or painted: 100, 101, 103, 104, 201, 202, 203, 204, 206, 207, 29, 300, 303, 304, 305, 308, 310, 402, 403, 404, 500, 501, 503, 505, 600, 603, and the Pavilion Dining Room. 2. Residents reside in rooms and common areas that have clean and/or freshly painted walls. 3. An in-service for facility personnel has been conducted pertaining to identification of cleaning and/or repair needs and proper notification to housekeeping and	8/17/10

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F 253	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations throughout the survey, the environmental tour with the facility maintenance and housekeeping staff on 6/7/10, and staff interviews, it was determined that the facility failed to provide maintenance and housekeeping services necessary to maintain an orderly and sanitary interior. Findings include: Scratched, dirty or unpainted areas of the walls were observed in resident rooms: 100, 101, 103, 104, 201, 202, 203, 204, 206, 207, 209, 300, 303, 304, 305, 308, 310, 402, 403, 404, 500, 501, 503, 505, 600, 603, and the Pavilion dining room. On 6/7/10, an interview with E12 (Facility Environmental Manager) confirmed this finding.	F 253	maintenance personnel by using work orders. An in-service has been conducted for housekeeping and maintenance staff pertaining to proper cleaning and maintenance of the facility. A weekly inspection will be conducted by the Environmental Services Manager to ensure that housekeeping and maintenance problems are identified and resolved. 4. The results of the weekly inspections will be presented to the QI Committee on a monthly basis for 6 months. Recommendations of the QI Committee will be followed.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence;	F 272	1. Resident R164 no longer resides in the facility. 2. Individuals admitted to the facility are impacted by the need to have an accurate comprehensive initial assessment, to include psychiatric diagnoses and medications which is the basis for all residents' plan of care. 3. An in-service will be conducted by the DON/designee to ensure that accurate and complete comprehensive assessments are conducted to include psychiatric diagnoses and medications. An audit will be conducted by the Director of Social Services/designee of 25% of	8/17/10

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F 272	Continued From page 13 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to conduct a thorough initial comprehensive assessment of one (R164) out of 57 Stage II sampled residents, which included the diagnosis of anxiety and depression as well as use of antidepressant medication. Consequently, the MDS did not trigger and the facility failed to develop a care plan for anxiety and depression. Findings include: Review of a hospital discharge history and medications, dated 12/18/09, listed a diagnosis of anxiety for R164 and indicated that she was taking Celexa 20 mg per day (antidepressant). These papers were faxed to the facility on 12/18/09, the day R164 was admitted. Review of the 12/09 Medication Administration Record revealed that R164 received Celexa daily beginning on 12/18/09. The facility History and Physical, dated 12/21/09, listed anxiety and R164 was ordered Xanax (for anxiety) to be given every 4 hours as needed.	F 272	MDSs for new admissions to ensure that psychiatric diagnoses and medications are included for 6 months.. 4. The Director of Social Services will present the results of the audits and the recommendations to the QI Committee. The recommendations of the QI Committee will be followed.	

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F 272	Continued From page 14 Review of the admission MDS assessment, dated 12/18/09, failed to list anxiety and depression as diagnoses and failed to list the use of antidepressant medication in the last 7 days. As a result, these areas did not trigger and care plans were not initiated. On 6/8/10, E3 (MDS Coordinator) was interviewed and findings were confirmed. E3 stated that even listing the use of an antidepressant on the admission MDS would have triggered the need for a care plan, which the MDS coordinator would have then initiated.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	1. The MDS for Resident R124 has been modified to reflect the level of support to be extensive assist of one person. The MDS for Resident R156 has been corrected to reflect total dependency for eating. The MDS for Resident R32 has had a significant change made to reflect a decline in ROM . 2. Those residents who have been identified with a decline in ROM, ADL (to include dressing and eating) will have a review of the MDS to ensure proper coding. 3. The MDS Coordinators will be in-serviced by the DON and/or designee to include accurate coding of the ADL and ROM sections of the MDS. This in-service will include how to properly compare MDS to best identify any change in the resident's ability. It will also include how best to review information and obtain accurate information from the interview process and then how to accurately	8/17/10

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F 278	Continued From page 15 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to accurately code the Minimum Data Set (MDS) assessments for three (R32, R124 and R156) out of 57 Stage II sampled residents. Findings include: 1. R124's admission Minimum Data Set (MDS) assessment, dated 12/16/09, coded this resident for dressing as "0/0" (independent/ no setup or physical help from staff). Review of R124's "Seven Day ADL (Activities of Daily Living) Tracker" from 12/9/09 through 12/16/09 indicated that R124 received extensive assist from one staff person for dressing (coding 3,2). Additionally, "Skilled Nursing Notes" for this same time period indicated the resident "needs a lot of assistance" with dressing. On 6/7/10 at 3:20 PM, during an interview with E3 (MDS Coordinator) and E4 (MDS Coordinator), they acknowledged that R124's 12/16/09 MDS was inaccurately coded as "0/0" for dressing. E3 and E4 stated that it should have been coded "3/2." 2. R156 was admitted to the facility on 1/28/10 with diagnoses that included status post intracranial hemorrhage/brain aneurysm and cerebral vascular accident (stroke) with right sided flaccidity. R156's cognitive skills for daily decision making were severely impaired and she	F 278	code the information obtained. An audit will be conducted by the DON/designee to randomly check 5 MDS per week for 3 months, then 3 MDS per week for 3 months to ensure accuracy of coding related to the ADL and ROM sections of the MDS. 4. The DON will present the results of the audits and the recommendations to the QI Committee on a monthly basis. The recommendations of the QI Committee will be followed.	

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F 278	Continued From page 16 was dependent on facility staff for activities of daily living (ADLs). R156 was NPO (nothing by mouth) and was receiving 100% of her nutrition via tube feedings. R156's admission MDS assessment, dated 2/4/10, coded the resident "3/2" (resident performed part of activity over last 7 days/one person physical assist) for eating. Review of the clinical record from 1/28/10 through 2/4/10 failed to indicate that R156 was actively involved during her tube feedings. During an interview with E4 (MDS Coordinator) on 6/14/10, E4 acknowledged that an error in coding had occurred and that the 2/4/10 MDS should have indicated that R156 was a "4/2" (full staff performance of activity during entire 7 days/one person physical assist) for eating. 3. R32 was admitted to the facility in 2007 and had diagnoses that included hypertension, seizure disorder and history of brain injury. A quarterly MDS assessment, dated 10/4/09, indicated that R32 had a range of motion limitation of both arms and a limitation on one side of the leg and foot. The annual MDS assessment, dated 1/4/10 and a significant change MDS assessment, dated 4/4/10, indicated that R32 continued to have a range of motion limitation of both arms. However, these MDS assessments indicated the resident now had a limitation on both sides of the leg and foot. Physical and occupational therapy screens, both dated 6/7/10, stated that the resident had not	F 278		

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F 278	Continued From page 17 experienced any changes in functional status. During an interview with E2 (DON) on 6/14/10, she stated that she had reviewed R32's record and that although the resident was gradually declining, there had been no change in the resident's ROM from 10/09 to 1/10. E2 stated that the facility had a new MDS coordinator and that she had coded the resident incorrectly. E2 also stated that the 4/10 MDS was completed by another new MDS coordinator and she coded what the previous coordinator had entered. E2 stated that MDS corrections for the 1/4/10 and 4/4/10 assessments would be submitted.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	1. Resident R177 has had the care plan corrected to reflect hospice service. Resident R136 has had the care plan changed to reflect the assistance needed with ADLs. Residents R154, R10, R164, R205, R166 and R137 no longer reside in the facility. 2. Residents in this facility who have been identified to have hospice services will have care plans reviewed to ensure that the care plan reflects hospice services. Residents with changes in their ADL abilities as identified on the MDS will have their care plans reviewed and updated to ensure the care plan reflects the current needs of the resident. Residents with a potential for skin breakdown have been reviewed to ensure that a care plan has been included for potential for skin breakdown care plan. Residents who	8/17/10

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F 279	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based upon interview and record review, it was determined that the facility failed to develop care plans based upon the comprehensive assessment for 9 (R10, R154, R177, R164, R6, R166, R205, R136 and R137) out of 57 Stage II sampled residents. Findings include: 1. R177 was admitted to the facility with hospice services on 1/22/10 and had diagnoses including Alzheimer's Disease. Review of the admission Minimum Data Set (MDS) assessment, dated 1/26/10, revealed that Hospice care was checked under programs received during the last 14 days. However, there was no end of life/hospice care plan for R177. The facility failed to develop a care plan for R177 related to end of life/hospice services. On 6/8/10, E7 (LPN) acknowledged that there was no care plan developed and that there should have been. 2. R154 was admitted to the facility on 1/28/10 with diagnoses including Alzheimer's Disease, pneumonia, and ADL (Activities of Daily Living)/ambulation dysfunction. The admission Nursing Assessment, dated 1/28/10, revealed in the Skin Condition section that R154's "Bottom pinkish-red, intact". The Pressure Ulcer Risk Assessment, dated 1/28/10, scored 14/15, indicating high risk. The admission MDS, dated 2/4/10, was checked for pressure relieving device for chair and for bed under the Skin Treatments section. Review of the Resident Assessment Protocol Summary (RAPS) for the admission MDS revealed that the RAPS	~~F 279~~	have been admitted within the past 30 days will have care plans reviewed to ensure the care plans reflect the relevant problems to include adjustment to the facility. Resident RAPS will be compared to care plans to ensure that those issues identified on the RAPS have a care plan to reflect the problem or have justification for why the care plan is not necessary. 3. An in-service will be conducted for the interdisciplinary team regarding accurate care planning of residents' specific problems related to information gathered on the comprehensive assessment. The initial care plans are completed by the Unit Manager and reviewed by the DON/designee at the morning meeting to ensure the care plans reflect the needs of the residents. The RNAC continues to follow the care plan process through the resident's stay to ensure that the Care Plan is comprehensive in addressing the needs of the resident. An audit will be conducted to randomly check 5 MDS per week for three months, then 3 MDS per week for 3 months. For accurate care planning of resident specific problems related to information gathered on the comprehensive assessment and per current regulations. This audit will be	

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F 279	Continued From page 19 were triggered for Pressure Ulcers and checked for care planning. The facility failed to develop a potential for skin breakdown care plan for R154. On 6/9/10, findings were confirmed by E2 (DON). 3. R10 was admitted to the facility on 12/21/09 with diagnoses including congestive heart failure, coronary artery disease, hypertension, chronic kidney disease and anxiety. On 1/2/10, lab tests reported that R10 had C. difficile, an illness causing diarrhea. Review of the admission MDS, dated 12/28/10, revealed that, "Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable" and "Resident experiences an acute episode of flare up of a recurrent or chronic problem" were both checked. R10's RAPS were triggered and care planning was checked in the areas of cognitive loss, dehydration/fluid maintenance, psychotropic drug use. However, there were no care plans developed in those areas. Additionally, there were no care plans developed related to R10's cardiac and kidney issues. The facility failed to develop care plans in the areas of cognitive loss, dehydration/fluid maintenance, psychotropic drug use as well as for cardiac and kidney issues for R10. On 6/14/10, findings were acknowledged by E2 (DON). 4: cross refer to F272 R164 was admitted to the facility on 12/18/09 with a diagnosis of anxiety and a history of taking	F 279	conducted by the RNAC and/or designee. 4. The results of the audits and the recommendations will be presented to the QI Committee by the RNAC on a monthly basis. The recommendations of the QI Committee will be followed.	

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F 279	Continued From page 20 antidepressant medication, which the facility continued. R164 was discharged from the facility on 1/19/10. Despite evidence of anxiety and depression, the facility failed to initiate a care plan for these areas. Additionally, the facility failed to initiate a care plan for placement in the facility (including approaches to make R164 feel welcome and to help with her adjustment to the facility). During an interview with E3 (MDS Coordinator) on 6/8/10 she stated that had R164's admission MDS assessment, dated 12/18/09 been completed correctly, anxiety and depression would have triggered and a care plan(s) would have been developed. E3 additionally stated that Social Service should have initiated a care plan for placement in the facility. 5. R205 was admitted to the facility on 4/27/10 with diagnoses that included end stage renal disease on hemodialysis, anemia and coronary artery disease. The admission Minimum Data Set (MDS) assessment, dated 5/3/10, indicated the resident's cognitive skills for daily decision making were independent. This same MDS indicated R205 had "pain less than daily" and "times the pain was horrible or excruciating." Review of R205's medication regimen revealed the resident was receiving narcotic pain medications daily. Although R205 was receiving pain medications daily, the facility failed to develop a care plan to address this resident's pain management. On 6/11/10, findings were acknowledged by E2 (DON). 6. Cross refer F318, example #1	F 279		

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F 279	Continued From page 21 R6 was readmitted to the facility post hospitalization on 10/2/09 with diagnoses that included stroke with left sided hemiplegia, hypertension and anemia. An "OT (Occupational Therapy) Initial Evaluation & Plan of Treatment," dated 10/2/09, noted that R6 had fixed contractures (tightening of muscle, tendons, ligaments, or skin that prevents normal movement) of the left elbow and wrist. The facility failed to develop a care plan for R6's left upper extremity contractures. On 6/11/10, findings were acknowledged by E2 (DON). 7. R166 was admitted to the facility on 12/23/09 and had a diagnosis of Alzheimer's dementia. Review of nurse's notes, dated 12/23/09, indicated that R166 had been agitated and wandering around the hallway. The physician's History and Physical, dated 12/23/09, stated that per discussion with family, the resident was often paranoid and agitated requiring antipsychotic and antianxiety medication. The admission Minimum Data Set (MDS) assessment, dated 12/29/09, indicated that R166 resisted care and was receiving antipsychotic and antianxiety medication. The RAPS (Resident Assessment Protocol Summary) triggered in the areas of behavioral symptoms and psychotropic drug use. The RAP Review Report indicated that behavioral symptoms would not be addressed in care planning and that psychotropic drug use would be care planned. There was no documentation supporting the decision not to care plan for behaviors found in the clinical record. Additionally, the facility failed to develop a care plan for psychotropic drug use. On 6/11/10, findings were acknowledged by E2 (DON).	F 279		

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F 279	Continued From page 22 8. R137 was admitted to the facility on 9/24/09 with diagnoses that included hypertension, hyperlipidemia, dementia, encephalopathy, and rehabilitation process. Review of R137's annual Minimum Data Set (MDS) assessment, dated 9/24/09, indicated that the RAPS triggered for ADL functioning and was checked off for care planning. R137's MDS indicated that R137 was totally dependent for Activity of Daily Living (ADL) such as dressing, eating, toilet use, bathing, and personal hygiene. The corresponding Resident Assessment Protocol Summary (RAPS) identified "ADL Functioning" as a problem area. R137's care plan, last revised on 4/15/10, lacked an ADL care plan. On 6/10/10, E8 (LPN) during an interview confirmed this finding. 9. R136 was admitted to the facility on 3/14/10 with diagnoses that included hip fracture, osteoporosis, Alzheimer's disease, anemia, depression, anxiety disorder. Review of R136's annual Minimum Data Set (MDS) assessment, dated 3/14/10, indicated that R136 required extensive assistance for personal hygiene, dressing, toilet use, bathing, and eating. The RAPS summary triggered for ADL functioning and was checked off for care planning. R136's care plan, last revised on 5/4/10, lacked an ADL plan to address her needs in the activity of daily living area. A physical therapy care plan	F 279		

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F 279	Continued From page 23 for ADL's was developed and in place until 5/14/10. No facility care plan was in place for R136 although resident was receiving the ADL care she required. In an interview, E4 (MDS Coordinator) on 6/11/10 and E27 (LPN) on 6/14/10 confirmed this finding. Additionally, on 6/14/10, in an interview, E2 (Director of Nursing) confirmed this finding.	~~F 279~~	1. The fall care plan for Resident R2 was updated to reflect current fall prevention interventions. Osteoporosis was included on the fall care plan. The ADL care plan for Resident R46 was updated to reflect 2 person assist for all transfers. The fall care plan was updated for Resident R46 to reflect current preventive interventions. The fall care plan for Resident R136 was updated to reflect use of psychotropic drugs. The fall care plan for Resident R20 was revised to include use of a safety alarm. Residents R199 and R10 no longer reside in the facility.	8/17/10
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to review and revise care plans for 6 (R2, R10,	F 280	2. Residents who are identified as being at risk for falls will have their care plans reviewed to ensure that reasons for fall risk as well as interventions are current. Care plans will be reviewed for those residents requiring some level of assistance with transfers to ensure that transfer needs are accurately reflected on the care plan. 3. The DON/designee will conduct an in-service pertaining to reviewing and revising individual care plans to ensure they reflect the current needs of the residents. The initial care plans are completed by the Unit Manager and reviewed by the DON/designee at	

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F 280	Continued From page 24 R20, R46, R136 and R199) out of 57 Stage II sampled residents. Findings include: 1. Record review indicated that R2 was known to have Osteoporosis since 2000. Review of the 6/10 Physician order Sheet stated, "Resident is not to participate in PROM (passive range of motion-exercises) due to severe osteoporosis". Review of R2's care plan revealed that the facility failed to include Osteoporosis as a potential for injury on the fall care plan. There were also multiple outdated interventions listed on the fall care plan including, "Instruct resident to sit at side of bed for one minute before standing,,, shoes well fitting with non-slip soles... toilet resident per schedule and request..." to name a few. Additionally, R2's contracture care plan was not revised to reflect that she should not have PROM due to severe Osteoporosis. Findings were confirmed with E6 (unit manager) during an interview on 6/8/10, E6 stated that R2 required total care by staff and had not been ambulatory for a long time. The fall care plan was subsequently updated on 6/8/10 post interview. 2. A physician order, dated 6/3/10, stated that R46 required a 2 person assistance for all transfers. Review of R46's care plan reflected that the facility failed to consistently revise the care plan to reflect 2 person assist for all transfers. The ADL (activities of daily living) care plan, dated 5/8/10, incorrectly stated that R46 required assistance of 1-2 persons for transfers. Review of R46's fall care plan, dated 5/4/10, listed	F 280	the morning meeting to ensure the care plans reflect the needs of the residents. The RNAC continues to follow the care plan process through the resident's stay to ensure that the Care Plan is comprehensive in addressing the needs of the resident. An audit will be conducted by the RNAC/designee to randomly check 5 individual resident's care plans per week for three months, then 3 resident's care plans per week for three months to ensure that care plans are being reviewed and revised as needed. 4. The results of the audits and the recommendations will be presented to the QI Committee by the RNAC on a monthly basis. Additional recommendations of the QI Committee will be followed.	

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F 280	Continued From page 25 interventions including use of a chair alarm, non-skid strips on the floor and must be supervised by staff at all times (implemented 5/24/10), to name a few. Observations on 6/9/10 revealed lack of a chair alarm, non-skid strips on the floor and constant staff supervision. E7 (unit manager) confirmed during an interview on 6/9/10 that the aforementioned fall interventions were not currently being done and he confirmed lack of consistency in revising the care plan for 2 person assistance with transfers. E7 further stated that the approach for constant staff supervision was inappropriate. 3. R136 was admitted to the facility on 4/15/10 with diagnoses including advanced Alzheimer's Dementia with agitation, anxiety and depression. Upon admission to the facility R136 received Zoloft (antidepressant), Klonopin (may be used to treat panic disorder), Seroquel (antipsychotic) and Ativan (for anxiety). Ativan was discontinued on 4/19/10 and changed to another antianxiety medication, Xanax. On 5/27/10, a physician's order was written stating that Klonopin, Seroquel and Ativan (?- was previously changed to Xanax) were being used for a diagnosis of dementia with delusions. Review of R136's fall risk care plan, dated 5/4/10, revealed multiple potential risks for injury, however, the facility failed to include the use of psychotropic medications. Further review revealed a care plan for activities/quality of life, dated 4/20/10, which included Alzheimer's disease with restlessness, anxiety and poor safety awareness. While the facility listed multiple approaches in the latter care plan, they failed to include the use of psychotropic medications	F 280		

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F 280	Continued From page 26 (including listing potential side effects/risks, GDR's (gradual reduction dosages) and monitoring mechanisms). Despite R136 being admitted to the facility on psychotropic medications, having multiple medication adjustments and her continuation to take antipsychotic medications, the facility failed to include the usage of psychotropic medications in R136's care plan. Findings were confirmed with E6 (unit manager) during an interview on 6/9/10. 4. R199 was admitted to the facility on 4/12/10 with diagnoses of C2 fracture of the cervical spine following a motor vehicle accident. Upon admission, R199's physician ordered that R199 was to wear a Miami J collar at all times for the C2 fracture. However, the Miami J collar fit poorly when R199 was admitted to the facility. After consulting with R199's orthopedic physician, on 4/16/10, a physician's order was written to use a soft cervical collar for comfort until advised by the orthopedist at R199's next appointment. Review of the care plan for fracture: potential for complications, dated 4/13/10, revealed that the care plan failed to be revised to reflect the use of the soft cervical collar for R199. Also, the care plan inaccurately stated that R199 had a T2 (thoracic spine) rather than C2 (cervical spine) fracture. The facility failed to revise the fracture care plan. On 6/14/10, findings were acknowledged by E2 (Director of Nursing).	F 280		

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F 280	Continued From page 27 5. R20 was admitted to the facility on 4/30/10, after surgical repair following a left hip fracture. Additional diagnoses included degenerative joint disease and dementia. On 5/30/10, R20 had an unwitnessed fall. On 6/10/10 R20 was observed in her wheelchair with a tether alarm on. The fall care plan, dated 5/30/10, failed to be revised to reflect the use of safety alarms. The facility failed to revise the care plan for R20. On 6/11/10, E6 (LPN Unit Manager) acknowledged the findings. 6. R10 was admitted to the facility on 12/21/09 with diagnoses including congestive heart failure and chronic kidney disease. On 1/11/10, R10's physician ordered fluid restriction of 1500 cc's/day. Review of the potential alteration in nutrition related to advanced age care plan, developed 12/21/09 stated, "Offer fluids at and between meals". The care plan failed to be revised to reflect R10's current status of a fluid restriction of 1500 cc's/day. On 6/14/10, findings were confirmed by E2 (DON).	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	1. Resident R205 no longer resides in the facility. 2. Residents who experience pain will receive pain medication at the times recommended by the physician. The effectiveness of the pain medication will be consistently documented. Documentation will reflect the effectiveness of the pain medication.	8/17/10

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F 309	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on closed record review and interview it was determined that the facility failed to ensure that one (R205) out of 57 Stage 2 sampled residents received the care and services to maintain the highest practicable physical, mental, and psychological well-being in accordance with the plan of care. The facility failed to administer Oxycontin (Oxycodone HCl - narcotic analgesic) to optimize pain control. Additionally, the facility failed to assess the effectiveness of this routine pain medication. Findings include: Cross refer F279, example #5 R205 was admitted to the facility on 4/27/10 with diagnoses that included end stage renal disease, coronary artery disease, anemia, and diabetes. The admission MDS assessment, dated 5/3/10, indicated that R205 had pain less than daily and that at times the pain is horrible or excruciating. On 5/7/10, a physician's order was written for R205 to receive Oxycontin 10 mg by mouth twice daily. Review of the 5/10 Medication Administration Record (MAR) revealed that the Oxycontin was timed as 8 AM and 6 PM for R205. Per the manufacturer's recommendations Oxycontin is expected to last for an extended period of time and contains enough medicine to last for up to twelve hours. (http://www.purduepharma.com/PI/Prescription/Oxycontin.pdf#page=28). R205 was receiving pain medication for back pain. The facility had a pain management flow	F 309	3. The DON will review and revise, as necessary, the Pain Management Policy and Procedure. An in-service will be conducted by the Staff Development Coordinator/designee for the licensed nursing staff. The in-service will include the proper use of the Pain Management Flow Sheets, accurate documentation of medication dosages administered, and administration of pain medications per manufacturer's recommendations. An audit will be conducted by the RNAC/designee of a random 20 residents per week for 6 months to ensure the following: 1) presence of pain, 2) the use of Pain Management Flow Sheets, 3) accurate documentation of medication dosages administered, 4) administration of pain medications per manufacturer's instructions, 5) whether the resident was treated for pain, and 6) did the resident receive adequate pain relief. 4. The results of the audits and the recommendations will be presented to the QI Committee by the RNAC on a monthly basis. Additional recommendations of the QI Committee will be followed.	

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F 309	Continued From page 29 sheet for the as needed (prn) pain medication to evaluate effectiveness. However, the 5/10 MAR revealed that the was no monitoring of the effectiveness of the Oxycontin. Nor was there consistent pain assessment related to the administration of Oxycontin in the 5/10 nurses' notes. The Control Drug record and the 5/10 MAR were not consistent. The Controlled Drug record indicated that on 5/13/10, R205 received a dose of Oxycontin at 2 PM and then a dose at 6 PM, a total of 4 hours between doses. On 5/24/10 a dose was signed off as given at 12 PM and then at 6 PM, a total of 6 hours. However, review of the MAR on 5/13/10 and 5/24/10 revealed that Oxycontin was signed off as given at 0800 (8 AM) and 1800 (6 PM). It is unclear how the facility could assess the effectiveness of this pain medication considering the inconsistencies in the documentation. On 6/11/10, E2 (DON) acknowledged the findings.	F 309	1. Resident R6 has fingernails trimmed and filed regularly. Resident R17 has facial hair regularly shaved. 2. Residents requiring assistance with Activities of Daily Living will be provided assistance with grooming and personal hygiene related to nail care and facial care as outlined on the individual care plan and per facility policy. 3. An in-service will be conducted for nursing staff on the facility policy on grooming and hygiene by Staff development Coordinator and/or designee. An audit will be conducted by the nursing supervisors/designee to randomly check 25% of the residents each week for 6 months to ensure that residents have their personal hygiene and grooming needs met as per their care plan related to nail care and personal hygiene. 4. The results of the audits and the recommendations will be presented to the QI Committee by the Nursing Supervisor on a monthly basis. Additional recommendations of the QI Committee will be followed.	8/17/10
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, it was determined that the facility failed to provide personal hygiene and grooming to two	F 312		

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F 312	Continued From page 30 (R6 and R17) out of 57 Stage II sampled residents who were unable to carry out activities of daily living. Findings include: 1. R6 was re-admitted to the facility post hospitalization on 9/19/07 with diagnoses that included stroke and hypertension. R6's quarterly Minimum Data Set (MDS) assessment, dated 5/25/10, indicated that he required extensive assistance from facility staff for personal hygiene. This same MDS indicated R6 had a functional limitation in range of motion (ROM) of one arm (including shoulder or elbow) and one hand (including wrist or fingers) with partial loss of voluntary movement. Observations of R6 on 6/1/10 revealed that the fingernails on his left hand were thick and elongated and in need of trimming. The right hand fingernails were trimmed. On 6/2/10, E8 (nurse) acknowledged that R6's left hand fingernails were elongated and in need of trimming. 2. R17 was admitted to the facility on 10/3/06 with dementia and degenerative joint disease. Review of the annual MDS, dated 10/8/09, revealed that R17 required extensive assistance of 1 person with grooming and bathing. On 6/3/10, resident was observed in the beauty parlor with facial hairs. On 6/10/10, R17 was again observed with a few long (1/2 to 3/4 inch) hairs on either side of her chin. On 6/10/10, during an interview with E6 (LPN Unit Manager) he stated that R17 required a Certified Nurse's Aide (CNA) to provide a shower and that	F 312		

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F 312	Continued From page 31 during that time the CNA would provide grooming to shave facial hair. E6 stated that R17 was unable to take care of her own facial hair or bring it to the staff's attention and that she was dependent upon the staff to provide the care. E6 observed the resident with the surveyor and agreed that R17 had long facial hairs on each side of her chin. The facility failed to provide grooming for R17.	~~F 312~~	1. Resident R154 no longer resides in the facility. 2. Residents in the facility will continue to have daily skin checks and weekly skin assessments. Residents at risk for breakdown on heels will have elevated heels. Residents at risk for skin breakdown and are not independent in bed mobility and/or wheelchair off-loading will be turned and positioned or repositioned every two hours. 3. The Pressure Ulcer Policy and Procedure will be reviewed and revised by the DON. This policy will address procedures, to include implications, for turning and positioning and for off-loading of heels when indicated by the individual care plan. Nursing personnel will be in-serviced regarding the revised Pressure Ulcer Policy and Procedure and the necessary documentation accompanying the policy. An audit will be conducted by the unit managers/designees of 20 residents per month for 6 months to ensure that the documentation on the Treatment Administration Records (TAR) and/or the ADL flow sheets is complete and accurate.	8/17/10
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that a resident who entered the facility without pressure ulcers (PU) does not develop pressure ulcers for 1 (R154) out of 57 Stage II sampled residents. Findings include: Cross refer F279, example #2 R154 was admitted to the facility on 1/28/10 with diagnoses including Alzheimer's Disease, pneumonia, interstitial lung disease (progressive scarring of lung tissue affecting the ability to get enough oxygen) and ADL (Activities of Daily Living)/ambulation dysfunction. The admission	F 314		

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F 314	Continued From page 32 Nursing Assessment, dated 1/28/10, revealed that R154's skin was, "Bottom was pinkish red intact". The skin diagram did not note any other skin issues. The Pressure Ulcer Risk Assessment, dated 1/28/10, was scored as 14/15, indicating high risk. The admission MDS assessment, dated 2/4/10 indicated the resident was totally dependent for bed mobility on two staff persons. The same MDS was checked for pressure relieving device for chair and for bed under the Skin Treatments section. Review of the Resident Assessment Protocol Summary (RAPS) for the admission MDS revealed that the RAPS were triggered for Pressure Ulcers and checked for care planning. However, the facility failed to develop a care plan for R154's high risk for developing PU. Review of the initial "Weekly skin assessment", dated 1/28/10, revealed "sacral area slightly red/pinkish, multiple small bruises to BUEs (bilateral upper extremities), small drsg (dressing) on top of R (right) hand intact and dry, no peripheral edema noted, heels dry/intact , feet look good". Skin assessments were also done on 2/1/10, 2/8/10, 2/15/10 and 2/22/10 that were all checked as, "Skin Clear". The skin assessment done on 2/27/10 was checked, "New Wound" and circled right heel with "Blister" written. Review of the Treatment Records (TARs) and CNA flow sheets from 1/28/10 through 2/26/10 did not reflect any interventions such as turning, positioning, and off loading. Review of the Skilled NN from 2/3/10 through 2/28/10 revealed that only three times in February on 2/1/10, 2/2/10 and 2/20/10 in the positioning section, "Every 2 hours or more often as needed", was checked as	F 314	4. The results of the audits and the recommendations will be presented to the QI Committee by the Unit Managers on a monthly basis. Additional recommendations of the QI Committee will be followed.	

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F 314	Continued From page 33 having been completed. On 2/27/10, a Nurse's note (NN) stated that R154 had an open area on the right heel. On 2/27/10, R154's physician ordered treatment to the right heel and to elevate the heel when in bed and at all times. There was no evidence of any measurement of the PU when it was first observed. The 2/27/10 physician's order stated, "Resident has an open area on r (right) heel cleanse with NSS (normal saline solution) then dry and apply foam dsg. (dressing). Elevate heels when in bed and all times". The order to elevate the heels was not transcribed onto the TAR and once again there was no evidence of off loading of R154's heels on 2/27/10 and 2/28/10. Review of the 3/10 TAR revealed that off loading of R 154's heels was documented. On 2/27/10, R154's physician also ordered, "Wound care nurse to evaluate R (right) heel". However, R154's right heel was not evaluated by the wound care nurse until 3/3/10, a delay of 4 days. Upon evaluation by the wound care nurse, measurements (5 centimeters (cm) x 7 cm x.2 cm, blistered open area with pink skin) were first obtained and there was a change in treatment. On 3/11/10, with treatment the right heel measured 0.5 cm x 1.0 cm x 0.1cm with no pain, no drainage, and + (positive) granulation (Granulation tissue is the fibrous connective tissue that replaces a fibrin clot in healing wounds. Granulation tissue typically grows from the base of a wound and is able to fill wounds of almost any size it heals). On 3/16/10, R154 expired.	F 314		

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F 314	Continued From page 34 The facility failed to prevent the development of a PU and failed to provide all the necessary treatment and services to promote healing of R154's PU. On 6/10/10, findings were acknowledged by the E2 (DON) and E1 (Administrator).	~~F 314~~	1. Residents R6 is presently on active therapy and is awaiting static splinting. R32 have been evaluated for therapy and has been picked up by Physical Therapy. 2. Facility residents with limited range of motion receive appropriate treatment and services to either increase his/her range of motion or to prevent further decline in range of motion. 3. The policy and procedure to increase and/or prevent further decrease in range of motion will be reviewed by the DON/designee. An in-service for nursing staff will be completed by Staff Development Coordinator/designee pertaining to optimizing and maintaining resident range of motion. At the time of the annual MDS assessment residents will be screened to identify those with limited range of motion who may benefit from a Restorative Nursing Program to maintain or improve range of motion. Those individual residents who are determined to need a restorative program will be care planned accordingly and an individualized program will be implemented. An audit will be conducted by the Unit Manager of 2 residents per month for six months to ensure residents with limited ROM	8/17/10
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that two (R6 and R32) residents with a limited range of motion, received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Findings include: Cross refer F279, example #6 1. R6 was originally admitted to the facility on 8/25/09 and readmitted post hospitalization on 10/2/09. R6's diagnoses included cerebrovascular accident (stroke) with left sided hemiplegia (severe or complete loss of motor function on one side of the body), hypertension and anemia. Review of the hospital Physical Therapy Department's inpatient initial evaluation, dated 8/14/09, revealed that R6's left shoulder, elbow and wrist were "rigid and fully flexed..." MDS	F 318		

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F 318	Continued From page 35 assessments from 10/9/09 through 5/25/10 indicated that R6 had a range of motion (ROM) limitation on one side of the body of the arm (includes shoulder or elbow) and hand (includes wrist or fingers). These same MDS assessments also indicated that R6 had partial loss of voluntary movement of the arm and hand and did not code the resident as having received any nursing rehabilitation/restorative care. An "OT (Occupational Therapy) Initial Evaluation & Plan of Treatment," dated 10/2/09, noted that R6 had fixed contractures (tightening of muscle, tendons, ligaments, or skin that prevents normal movement) of the left elbow and wrist. The therapy services included passive stretch/ROM to all joints of the left upper extremity. R6 was discharged from OT services on 10/30/09. Review of R6's clinical record lacked evidence of any ROM measurements, or that the resident was on a restorative/maintenance program. The facility failed to develop a plan of care for R6's contracture management. During an interview with E18 (Director of Rehab Services) on 6/7/10 at 10:50 AM, E18 stated that back when R6 was discharged from therapy on 10/30/09, it was believed that the resident would be going to live at a private residence. E18 stated that therapy would teach and show nursing staff how to perform ROM on a resident who required a restorative or maintenance program. E18 also stated that contracture measurements were not done at the facility. Additionally, he stated that if a resident experiences a decline, nursing would inform them of the need for an evaluation. On 6/7/10 at 3 PM, E7 (nurse) stated that the	F 318	receive appropriate treatment and services for maintaining or increasing range of motion. 4. The results of the audits and the recommendations will be presented to the QI Committee by the Unit Managers on a monthly basis. Additional recommendations of the QI Committee will be followed.	

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F 318	Continued From page 36 facility had no restorative/maintenance program and that contracture measurements were not being done currently. E7 acknowledged that there was no care plan for R6's contractures. In an interview with E17 (OT) on 6/8/10 at 8:30 AM, E17 stated that R6 was discharged from skilled therapy services with the belief that he might be going home. E17 stated that when R6 became a permanent resident, therapy services should have developed a contracture management program or nursing should have notified therapy services regarding R6's contractures and a program should have been developed. Cross refer F278, example #3 2. R32 was admitted to the facility in 2007 and had diagnoses that included hypertension, seizure disorder and history of brain injury. A significant change MDS assessment, dated 4/4/10, indicated the resident's cognitive skills for daily decision making were moderately impaired and that he had short and long term memory problems. This same MDS indicated that R32 was totally dependent on facility staff for all activities of daily living (ADL). R32's care plan for the problem, "ADL assistance/assist of 1-2 for care..." included the intervention, "ROM (range of motion) x 10 minutes TID (3 times daily) to all extremities." Review of R32's clinical record lacked evidence that the resident was on a restorative program. The facility failed to provide ROM three times a day per the plan of care. On 6/11/10, E2 (DON) acknowledged the findings.	F 318		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=E	Continued From page 37 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain an environment free from accident hazards as evidenced by loose cords on the floor of R109's room, water on floor in R211's room that posed a potential fall hazard, unsecured toilet safety rails for R36, unattended and unlocked medication room and supply room, and a call bell out of reach posing a fall hazard for R204. Additionally, R206 had bilateral grab rails on the bed that were loose and tilted outward. Findings include: 1. On 6/2/10 and 6/7/10, observations of R109's room revealed that electrical cords (cable and power to the TV) were lying on the floor of the bedroom. The cords were loose on the floor and were a potential tripping/accident hazard. On 6/7/10, E12 (Environmental Services Manager/ESM) confirmed that the cords were a potential tripping hazard and corrected the problem temporarily by placing cords behind the dresser. 2. Observations on 6/7/10 at 4:11 PM of resident room 501 (R209) revealed a pool of water on the	F 323	1. The loose cords in Resident R209's floor has been secured to avoid tripping hazard. The water found in Resident R211's room has been cleared for the floor. The safety rails in R36's room have been secured and repaired to avoid a safety hazard. The cabinet in the Supply room is locked when not in use and the door to the Supply Room shuts and locks automatically. The Medication Room inside the East Wing nursing station shuts and locks automatically.R204's call bell is within her reach at all times when in her room.R206's grab rails for her bed have been secured properly. 2. Resident rooms and common areas are free from loose cords lying on the floors. Liquids found on the floor are immediately wiped up to avoid a hazard. Safety rails in bathrooms are in good repair and are secured so as to avoid an unsafe situation. The supply room and the medication rooms have automatic locks to prevent unauthorized persons from entering the rooms. 3. Facility staff will be in-serviced by the Staff Development Coordinator pertaining to ensuring a environment that is as free from hazards as possible for the residents. A non-clinical audit will be conducted by the	8/17/10

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F 323	Continued From page 38 center of the bathroom. During an interview with R209, he stated that he was not aware there was water on the floor in the bathroom. On 6/8/10, an interview with E12 (Environmental Manager) revealed that the nursing aides had used the sprayer to care for the resident that day and did not clean the water off the floor or contact housekeeping to clean up the puddle of water. This created a potential fall hazard. 3. Observation of R36's bathroom on 6/7/10 revealed that the toilet assist safety rails were unstable and in disrepair (legs angled back and rubber tips missing). On 6/7/10, E12 (ESM) was able to easily remove the rails and agreed that it was a potential hazard and stated that the toilet assist rails would be replaced. 4. Observations on 6/7/10 at 10:59 AM revealed the West Wing medical supply room was unlocked. A cabinet in the medical supply room contained medical supplies and was observed unlocked. The cabinet stored medicines and other hazardous items such as Vitamin C, Folic acid, Calcium, Antifungal creams, Calmoseptine, approximately 25 scissors, and boxes of syringes. A small label on the door stating "this door must be locked at all times" was observed. On 6/7/10, an interview with E9 (Supply Coordinator) confirmed this finding. 5. Observations on 6/9/10 at 4:43 PM revealed the medication room inside the East Wing nursing station was unlocked and the room and area were unattended for more than 10 minutes while residents were nearby. On 6/9/10, an interview with the E6 (LPN Unit Manager) confirmed this finding.	F 323	Environmental Services Manager on a weekly basis to ensure as hazard free environment as possible for residents. 4. The results of the audits and the recommendations will be presented to the QI Committee by Environmental Services Manager the on a monthly basis. Additional recommendations of the QI Committee will be followed.	

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F 323	Continued From page 39 6. On 6/1/10 at 3:43 PM, R204 was observed alone in her room and with her call bell out of reach. A call bell was observed on the bed and another one was on top of the bedroom light. Both call bells were out of reach of the resident. On 6/1/10, an interview with R204 revealed her condition would not allow her to reach either of the two call bells. She said she had to scream if she needed help. R204 was admitted from the hospital on 4/22/10 and had diagnoses which included deep vein thrombosis, cerebrovascular accident stroke, and hemiplegia/hemiparesis. The resident's initial MDS, dated 4/29/10, indicated the resident required extensive assistance with transfer, bed mobility, did not ambulate and used a wheelchair. Review of Resident R204's fall care plan, revised on 5/2/10, revealed the approach to encourage resident to use the call bell. On 6/1/10, an interview with E28 (CNA) confirmed that the call bells were out of reach. 7. R206 was admitted to the facility on 5/20/10 and had diagnoses that included dementia, hypertension and ambulatory dysfunction. R206's admission MDS assessment, dated 5/27/10, revealed that this resident required extensive assistance of one person for bed mobility and transfers. Review of R206's Fall Risk Assessment, dated 5/20/10, revealed that R206 scored "23" which indicated that she was a high risk for falls. (A score of 7+ is considered at "Higher Risk"). During R206's resident interview on 6/1/10 at 4:30 PM, the bilateral grab assist rails on the bed were both observed loose and tilted outward. Upon	F 323		

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F 323	Continued From page 40 further inspection, there was found to be about a 5 inch movement/play in each rail, posing a potential accident hazard. The facility failed to ensure that the grab rails were secured properly. Findings were acknowledged by E12 (Environmental Manager) and E13 (Housekeeping Supervisor) promptly tightened both rails.	F 323	1. Indications for use of Gabapentin and Sinemet has been obtained by the physician for Resident R23. Blood sugar levels for Resident R23 are taken per physician orders. Resident R 97 no longer resides in the facility. The pain medication effectiveness for Resident R208's is being monitored on the Pain Management Flow Sheet. Indications for use of Benadryl for Resident R177 has been reviewed by the physician and ordered accordingly. 2. Indications for use of medications are being recorded on the MAR (Medication Record Administration) for residents. Blood sugar levels for residents are obtained as ordered. Effectiveness of pain medication is being recorded for those residents using pain medication by the use of the Pain Management Flow Sheet. 3. Medication Administration Policy and Procedure has been reviewed and revised by the DON/designee to include indications for use of medications. Current policy and procedure for checking blood sugars will be reviewed and revised by the DON/designee to include following sliding scale as ordered. The current policy and procedure for pain management will be reviewed and	8/17/10
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329		

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F 329	Continued From page 41 by: Based on record reviews, review of hospital records and interviews, it was determined that the facility failed to administer medications without adequate indications for use and/or failure to adequately monitor the medications for 4 (R23, R97, R177 and R208) out of 57 Stage II sampled residents. Findings include: 1. A. R23 was admitted to the facility from the hospital on 4/8/10 with orders for medications including Gabapentin (Neurontin) and Carbidopa/levodopa (Sinemet). These medications were reordered by the facility upon admission, however, indications for use of Gabapentin and Sinemet were not found in the active or in the hospital records. 1. B. Additionally, review of R23's 6/10 Medication Administration Record revealed sliding scale coverage with Regular Insulin for blood sugars (BS) >350, give 9 units (u) of Insulin, recheck BS and cover (with appropriate dosage of Insulin according to sliding scale) in 4 hours. On 6/7/10 at 12 PM, R23's BS was 372 and she was appropriately covered with 9 u of Insulin. However, record review revealed lack of rechecking (with possible additional Insulin coverage) of the BS at 4 PM. On 6/11/10, E16 (LPN) confirmed findings. E16 further stated that she was the nurse that gave R23 9 u of Insulin for BS 372 on 6/7/10 at 12 PM. She stated that she left at 3 PM and she was unable to recall if she passed on in report that R23 needed a BS to be done at 4 PM with possible coverage. 2. R97 was admitted to the facility on 5/26/10.	F 329	revised to include monitoring for effectiveness of pain medications. Licensed staff will be in-serviced on the following revised policies and procedures by the Staff development Coordinator: documentation of indication for medication use by the physician, monitoring of blood glucose and use of sliding scale coverage as ordered, and documentation of effectiveness of medication usage in reference to pain medication use. An audit will be conducted by the Unit Managers/designee of 20 charts per week until all current residents have been evaluated than 10 random charts per week will be checked for three months, then 5 charts will be checked per week for 3 months. 4. The results of the audits and the recommendations will be presented to the QI Committee by the Unit Managers on a monthly basis. Additional recommendations of the QI Committee will be followed.	

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F 329	Continued From page 42 Review of the 6/10 Medication Administration Record revealed that R97 was receiving Prilosec 40 mg by mouth daily and Neurontin 100 mg 1 capsule by mouth at bedtime. Review of the clinical record and hospital records lacked indications for use for these medications. Findings were confirmed with E5 (Staff Development Nurse) during an interview on 6/14/10. 3. The facility's policy entitled, "Pain Management" was reviewed. Review of R208's 6/10 medication administration record (MAR) revealed the resident was receiving Vicodin (narcotic analgesic combination)) 5/500 mg 1 tablet by mouth every 6 hours as needed for moderate to severe pain. The 6/10 MAR noted that the resident had received 8 doses of Vicodin from 6/1/10 through 6/8/10. Review of the, "Pain Management Flow Sheet" revealed that only on 3 occasions did the facility rate the resident's pain using a numerical scale from 1 to 10. Although staff noted on the back of the MAR on 4 occasions that the Vicodin was "effective," they failed to use the numerical pain rating scale as per facility policy to monitor for the effectiveness. Additionally, on the other 4 occasions there was no monitoring for effectiveness. The facility failed to consistently monitor the effectiveness of R208's pain medication. On 6/11/10, E2 (DON) acknowledged the findings. 4. R177 was admitted to the facility on 1/22/10.	F 329		

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F 329	Continued From page 43 On 1/23/10, R177's physician ordered Diphenhydramine (Benadryl) for a rash. Review of the clinical record revealed in a skilled nursing note, dated 1/28/10, that R177's skin condition was intact and rash was not checked. Additionally, the weekly skin assessment, dated 2/2/10, noted that R177's skin was clear. On 6/8/10, in an interview with E7 (LPN Unit Manager), he acknowledged upon review of R177's clinical record, that R177's rash was resolved as of 1/28/10. However, E7 confirmed that R177 continued to receive Benadryl. Benadryl remained on R177's Physician Order Sheet (POS) from 1/23/10 when it was originally ordered through the 5/31/10 POS and it was administered to R177. The facility failed to identify that diphenhydramine (Benadryl), ordered 1/23/10 for rash which was resolved by 1/28/10, remained on the POS and was administered to R177 from 1/28/10 through 5/31/10 long after the rash was resolved (lack of indication). Additionally, the facility failed to identify that Benadryl was not discontinued in the January 24 hour chart check. On 6/8/10, findings were acknowledged by E7.	F 329		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356	1. Facility posting of staffing information is provided on a daily basis to include direct nursing staff numbers and hours with census per shift. 2. The facility posts the following information on each unit: facility name, current date, number of licensed and unlicensed direct staff for residents per shift and the resident census. The facility has available a minimum of 18 months of staffing and census to be provided upon written or oral request to the public.	8/17/10

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F 356	Continued From page 44 - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to post the daily nursing schedule in a prominent place readily accessible to residents and visitors. Findings include: On 6/2/10 at 3:35 PM, 6/7/10 at 8:01 AM and 6/11/10 at 11:55 AM, the required postings of the nurse's daily schedules were not posted for public viewing on the East wing nurses station display board. An interview with E2 (DON) on 6/11/10 at 12:05 PM confirmed this finding.	F 356	3. The procedure for posting of daily staffing will be reviewed and revised as necessary. The RN Supervisors will be educated concerning the proper posting of daily nursing schedules by the DON/designee to include facility name, current date, number of licensed and unlicensed direct staff for residents per shift and the resident census. RN Supervisor/designee will audit the staffing posting 7 shifts per week for 1 month, 5 shifts per week for 2 months, then 3 shifts per week for 3 months. 4. The results of the audit will be presented to the QI Committee by the ADON (Assistant Director of Nursing)/designee with recommendations every other month for 6 months. Recommendations of the QI Committee will be followed. 1. Residents R30 and R184 receive the properly prepared foods at each meal. 2. Resident meals are checked for proper name and consistency of food prior to presenting to the resident at each meal. 3. The procedure for passing of food trays at meals will be reviewed by the Dietary Manager and DON.	8/17/10
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS	F 365		

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F 365	Continued From page 45 Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that two (R30 and R184) out of 57 Stage II sampled residents received food prepared in a form designed to meet individual needs. Findings include: 1. R30 was ordered to have a "soft to chew" diet. During the evening meal observation on 6/8/10, R30 was noted to have incorrectly received R184's plate, which consisted of a "regular" diet. Although the food items were the same, R30's food was to be ground. R30 completed the entire meal without any difficulty. In an interview with E2 (DON) immediately after the observation, she acknowledged that the wrong plate had been served to R30. 2. R184 was ordered to have a "regular" diet. During the evening meal observation on 6/8/10, R184 was noted to have incorrectly received R30's plate, which consisted of a "soft to chew" diet. In an interview with E2 (DON) immediately after the observation, she acknowledged that the wrong plate had been served to R184.	F 365	Same names (first and/or surname) will be highlighted to ensure attention is given to the appropriate name. Each resident will have an arm band which will be used for identification. Facility personnel will be in-serviced by the Staff development Coordinator/designee on the procedure for passing trays in the dining rooms to ensure each resident received food prepared in a form designed to meet individual needs. An audit will be conducted by Unit Managers/designee of 25 trays per week for 1 month, then 15 trays for 2 months, than 10 trays for 3 months to ensure that the proper consistency is provided for each resident during meal times. 4. The results of the audits and the recommendations will be presented to the QI Committee by the Unit Managers on a monthly basis. Additional recommendations of the QI Committee will be followed.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F371 F 371	1. The temperature of the steam table has been increased to hold the food at the proper temperature of 141°F. Meat loaf pans have been cleaned to have no grease spots on non food-contact surfaces. A thermometer is in place in the kitchen milk refrigerator. The outside thermometers of the McCall refrigerator, the beverage refrigerator	8/17/10

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F 371	Continued From page 46 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews in the dietary area on 6/1/10 and 6/2/10, it was determined that the facility failed to prepare, serve and store food under sanitary conditions. Findings include: 1. Observation on 6/2/10 at 11:15 AM of E31 (dietary staff) taking temperatures of the food at the steam table in the kitchen revealed all the food except for the pasta was tested. Observation of the Wedgewood dining area steam table on 6/2/10 at 11:25 AM by the same staff revealed the temperature of the pasta to be at 116.5 degrees Fahrenheit (F) (should be at least 141 degrees). E31 was then observed going back to the kitchen to continue with his work but failed to report the temperature problem to the supervisor. The surveyor reported the concern to the E29 (Dining Service Director) who stated that the pasta needed to be reheated to the proper temperature. Afterwards, the pasta was retested and measured 136 degrees Fahrenheit, which was still below the safe holding temperature, and it was then served to the residents at 12:05 PM. On 6/14/10, an interview with the E30 (Dietary	F 371	and the Kalpak walk-in refrigerator have been replaced. 2. The temperature of the steam table is maintained to hold the food at the proper temperature of 141°F or higher. Meat loaf pans are consistently cleaned to remain free of grease spots. The outside thermometers of the McCall refrigerator, the beverage refrigerator and the Kalpak walk-in refrigerator reveal the accurate temperatures of the respective refrigerators. 3. The temperature policy and procedure has been reviewed by the Dietary Manager. Dietary staff has been in-serviced by the Dietary manager on proper temperatures for food products. The cleaning of kitchen pots and pans has been reviewed by the Dietary Manager. Dietary staff has been in-serviced by the Dietary Manager on proper cleaning procedures for pots and pans. The Dietary Manager/designee will audit kitchen utensils one time per week for 6 months to ensure that kitchen utensils are free of grease spots. The Dietary manager/designee will audit temperatures of the steam table 7 times per week for one month, then 4 times per week for five months to ensure that foods are presented at proper temperatures.	

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F 371	Continued From page 47 Food Supervisor) revealed that the staff should not have left the food on the steam table if the temperature was below 140 degrees F. She stated that the staff were supposed to bring food back to the kitchen to be heated to the proper temperature. 2. Observation on 6/1/10 at 12:45 PM of a stack of two meat loaf pans revealed that the non food-contact surfaces contained grease deposits. Additionally, the food contact area of five (5) of six (6) plastic resident plates stored on the plate warmer were observed stained and/or encrusted with food debris. 3. Observation of the kitchen milk refrigerator on 6/1/10 revealed a missing thermometer. On 6/1/10, an interview with E29 (Dining Services Director) confirmed this finding. 4. During the tour of the kitchen with the E29 on 6/1/10 at 12:20 PM, refrigerator and freezer units outside temperature gauges were in disrepair and were not reading the correct temperatures inside the units. The following were observed: - The McCall refrigerator (ice box) outside temperature gauge indicated a temperature of 68 degrees F. The actual temperature inside the unit was measured at 43 degrees Fahrenheit. - The beverage refrigerator containing milk products outside temperature gauge indicated a temperature of 43 degrees F. The actual temperature inside the unit was 26 degrees F. - The Kalpak walk-in refrigerator outside temperature gauge indicated 38 degrees F. The actual temperature inside the unit was 20 degrees F. - The Kalpak walk-in freezer outside temperature gauge indicated 16 degrees F. The actual	F 371 F372	4. The results of the audits and the recommendations will be presented to the QI Committee by the Dietary Manager on a monthly basis. Additional recommendations of the QI Committee will be followed. 1. Cardboard boxes are broken down and plastic is placed in refuse containers. Wooden pallets are removed from the ground and returned to the company. 2. Facility staff ensure that refuse is disposed of properly into containers and that wooden pallets are returned to the respective company. 3. A schedule has been developed to ensure that refuse is properly contained in appropriate receptacles. An in-service has been provided by the Environmental Services Manager to facility staff regarding proper placement and disposal of refuse to include plastic, cardboard and wooden pallets. The Environmental Services Manager will conduct an audit of the refuse areas in and around the facility 5 times per week for two month, then 3 times a week for four months to ensure refuse is properly contained. 4. The results of the audits and the recommendations will be presented to the QI Committee by the	8/17/10

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F 371	Continued From page 48 temperature inside the unit was 8 degrees F. On 6/1/10, E29 confirmed these findings.		Environmental Services Manager on a monthly basis. Additional recommendations of the QI Committee will be followed.	
F 372 SS=B	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations on 6/1/10 with E29 (Dining Services Director), it was determined that the facility failed to dispose of refuse properly. Findings include: Observation on 6/1/10 at 1:05 PM of the dumpster area outside the kitchen revealed two wooden pallets, plastic wrap and cardboard on the ground. This provided harborage for unwanted pests in the facility. On 6/1/10, E29 confirmed this finding.	F425	1. The expired medications in the East Wing Medication Room emergency narcotic box have been sent back to the pharmacy for disposal. The expired influenza vaccine vial in the medication refrigerator of the East Wing was removed and destroyed. 2. Medications in the Medication Room refrigerators are checked on a monthly basis to ensure that residents are safe from expired medications. Any resident in the facility can be impacted by medication that is expired.	6/17/10
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	3. The 11-7 shift licensed staff has been assigned to check for expired medications in the medication refrigerators on a monthly basis. The facility consultant pharmacist will monitor the refrigerators on a monthly basis to ensure that all expired medications are removed from the refrigerators. 4. The results of the audits and the recommendations will be presented to the QI Committee by the consultant pharmacist on a monthly basis for three months and then on a quarterly basis. Additional recommendations of the QI Committee will be followed.	

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F 425	Continued From page 49 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that pharmaceutical services provided met the needs of each resident. Findings include: On 6/11/10 at 3:15 PM, during observation of the East Wing medication room the following expired medications were found: - in the medication refrigerator - one (1) vial of influenza vaccine, expiration date 5/10/10. - in the emergency narcotic box - Restoril 7.5 mg capsule, expired 12/09 and Propoxyphen-APAP 10-650 mg tablet, expired 6/09. E6 (nurse), present during the observation, acknowledged that the medications were expired.	F 428	1. Resident R177 has had the indication of pruritus for the identified medication 2. Medications are reviewed on a monthly basis for each resident in the facility. When irregularities in medication are identified, such as the reason for the medication is no longer evident, the consultant pharmacist will submit a request for a review to the attending physician. 3. An independent consultant pharmacist has been contracted to provide consultative services to include the Medication Regimen Review. The consultant pharmacist will identify medications that appear to be no longer indicated or otherwise contra-indicated and will request review by the attending physician. The consultant pharmacist will in-service licensed nursing personnel pertaining to MRR findings and the responses from the physicians. An audit will be conducted by the ADON/designee to review 5 residents per month for unidentified medication irregularities. This audit will continue for 6 months, or for the length of time as recommended by the QI Committee. 4. The ADON will present the findings of the audits to the QI Committee for a period of 4 months and then quarterly.	F 428 8/17/10
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			

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F 428	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that during the medication regimen review (MRR) the consultant pharmacist identified and reported irregularities to the attending physician and the director of nursing, and these reports were acted upon for 1 (R177) out of 57 Stage II sampled residents. Findings include: R177 was admitted to the facility on 1/22/10. On 1/23/10, R177's physician ordered Diphenhydramine (Benadryl) for a rash which was resolved by 1/28/10. Benadryl remained on R177's POS from 1/23/10 when it was originally ordered through 5/31/10. Benadryl continued to be administered to R177 throughout this entire time. Review of R177's MRRs done on 2/5/10, 4/2/10, and 5/14/10 revealed that for each of those months the box, "No New Suggestions" was checked. There was no review date, and the review in the notes section and signature area was blank for 3/10. The facility failed to identify during the monthly MRRs that R177 continued on Benadryl without adequate indication for use and for a prolonged duration. Since this was not identified during the MRRs, consequently it was not acted upon. On 6/8/10, findings were confirmed by E7 (LPN Unit Manager).	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 51 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	1. Monthly tracking of infections to include type of organisms, trending the organisms to determine if there is a pattern of infection needed to be address and consequently what preventive program has been put into place. The East Wing soiled linen cart is now closed. Soiled linen is placed in a large bin inside the soiled linen room. Staff are carrying soiled linen bags rather than dragging them on the floor. Soiled linen bags are not found on the floor. Resident R55 is provided sandwiches that are not handled without gloves. The employee has been educated regarding this practice. There is ventilation in the laundry room to remove contaminated air. The employee identified has been instructed regarding the need not to touch her hair without then washing her hands before assisting a resident with a meal. 2. The Infection Control Committee meets monthly and reviews the tracking and trending of infections and recommends and implements preventive programs/interventions to eliminate infections from spreading. All linen carts are closed to ensure prevention of spreading airborne contaminates. There are several bins available in the soiled linen room where soiled linen is placed rather	8/11/10

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F 441	Continued From page 52 by: Based on observations, review of facility documents and staff interviews, it was determined that the facility failed to maintain an infection control program regarding ongoing surveillance designed to prevent the development and transmission of disease and infection, and failed to follow recommended handling, washing, and storing of soiled linen. Additionally, staff were observed assisting residents with food without washing their hands after touching their hair and touching food with their bare hands Findings include: 1. Review of Monthly Infection Control Logs on 6/11/10 revealed that the facility monitored the occurrence of infections, however, it failed to identify the type of organisms infecting the residents and failed to trend the organisms to determine if there was a pattern of infection that the facility needed to address and implement corrective actions. Additionally, the facility failed to implement an infection control program under which it investigated and analyzed any increase in the rate of infection, and established controls to prevent infections in the facility. Review of the facility's Infection Control Policy and 2009 to 2010 Monthly Infection Records with E5 (Infection Control Nurse, ICN) on 6/11/10, the following was revealed: there were monthly nosocomial infection reports for all units from 1/09 through 5/10 but none showed proper tracking of the infections. There was no tracking of infection data such as resident name, room number, the date of onset, diagnosis, symptoms, culture data, notification to family and doctor, and interventions until the week of 6/1/10. The infectious organisms were still missing in the new infection tracking	F 441	than on the floor. The East Wing soiled linen cart is now closed. Soiled linen is placed in a large bin inside the soiled linen room. Staff has been instructed on carrying soiled linen bags rather than dragging them on the floor. Staff has been instructed to ensure that soiled linen bags are not left on the floor. When cutting resident meals, staff use sanitary procedures so as not to expose the food to bare hands. Ventilation in the laundry room has been repaired to ensure elimination of contaminated air. The employee identified has been instructed regarding the need not to touch her hair without then washing her hands before assisting a resident with a meal. 3. An Infection Control Program has been revised and updated to include ongoing surveillance designed to prevent the development and transmission of disease and infections. An Infection Control Committee reviews tracking and trending of infections on a monthly basis and provides recommendations to the QI Committee. An in-service will be conducted by the Staff Development Coordinator and the Environmental Services Manager for facility staff to include: proper handling of soiled	8/17/10

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F 441	Continued From page 53 logs. Review of infection tracking data prior to June 2010 revealed that documentation included units, type of disease (such as respiratory, surgical wound, total IVs, etc), and a total count for each unit; however it did not specify any other information. Monthly tracking data review from 1/09 to 1/10 revealed that the facility had no record of how the facility analyzed and responded to the data. E5 stated that the facility did not have a formalized monitoring and tracking system in place to control, investigate and prevent infections in the facility until June 2010. On 6/14/10, E2 (DON) and E5 (ICN) confirmed these findings. 2. Observations on 6/7/10 at 10:45 AM of the clean linen area of the central laundry revealed that one door was opened to the hallway next to kitchen and the other door was opened to the soiled linen wash area. During the kitchen tour on 6/1/10 at 12:20 PM, the door to the clean linen area of the central laundry was observed open to the hallway. An opened door has the potential of spreading airborne contaminates. 3. On 6/7/10 at 10:45 AM, three bags of soiled linen were observed on the floor of the laundry soiled linen receiving area. On 6/7/10, in an interview E32 (Laundry staff) revealed the bags should be in barrels or carts of soiled linens and not on the floor. Additionally, these other observations of linen handling were made during the survey: a. On 6/7/10 at 9:46 AM, a soiled linen cart in the East Wing Central resident bathroom was observed with the cart lid open. On 6/7/10, in an	F 441	linen, handling of food for residents, and hand washing (when to). The Infection Control Nurse will be in-serviced regarding Infection Control principles and proper tracking and trending of infections. This in-service will be conducted by the DON/designee. The preventive maintenance program has been reviewed and revised by the Environmental Services Manager to include the mechanical ventilation system. Infection Control tracking and trending reports will be monitored weekly for 6 months by the ADON/designee to ensure there is a formalized monitoring system in place to control, investigate and prevent infections in the facility. The Environmental Services Manager and the Infection Control nurse will audit the environment for infection control issues to include handling of linen, dining room infection control practice, and the ventilation system functioning. 4. The Environmental Services Manager and the Infection Control Nurse/designee will present the findings of the audits to the QI Committee for a period of 6 months and then quarterly or at the recommendation of the QI Committee.	

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	085042	A. BUILDING _____ B. WING _____	C 06/15/2010

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F 441	Continued From page 54 interview E12 (Environmental Manager) revealed they should be kept closed. b. On 6/2/10 at 8:30 AM, two bags of soiled linen were observed being dragged on the floor of the 500 unit hallway to the soiled utility room by housekeeping staff. c. On 6/3/10 at 9:48 AM, two bags of soiled linen were observed on the floor in resident room 403. 4. On 6/7/10 at 10:55 AM, the washer and receiving area of the laundry had no mechanical ventilation to remove contaminated air to the outside. The area was not maintained under a relative negative pressure. 5. On 6/2/10 at 12:10 PM, E9 (CNA) was observed handling R55's sandwich with bare hands. 6. On 6/8/10 at 5:30 PM, E10 (CNA) was observed touching her hair and then serving two (2) cups of fluids to R46. 7. On 6/8/10 at 5:35 PM, E10 was observed touching her hair and then serving plated food to R79. 8. On 6/8/10, during the evening meal, E10 was observed touching her hair prior to feeding R137.			
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456	1. The washing machines are set and register at 160° F. for all washing cycles. There were sufficient tanks to meet the proper temperature of the washing machines.	8/17/10

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F 456	Continued From page 55 This REQUIREMENT is not met as evidenced by: Based on observations in the laundry area, and interviews, it was determined that the facility did not consistently maintain the hot water temperature of the laundry washer above the 160 degrees Fahrenheit (F) as required by regulations. Findings include: On 6/7/10 at 10:45 AM, the washer hot water temperature was 140.3 degrees F while soiled bed linen was washing. On 6/7/10 at 11:47 AM, the hot water temperature of the washer was tested at a temperature of 165 degrees (F). On 6/7/10 in an interview, E33 (Maintenance staff) stated they are short one tank so the supply water to the washers does not always maintain the required minimum of 160 degrees F when washing soiled linen. On 6/7/10, an interview with E12 (Environmental Services Manager) confirmed this finding.	F 456	2. The washing machines are set at the proper set program which enables the temperature to remain at 160° F. 3. Laundry staff has been in-serviced on the regulation set forth on water temperature that is required to maintain sanitary conditions. The in-service also includes correct operation of the washing machines. This in-service reviews the temperature log and actions to be taken when the temperature does not meet the required temperature. The Environmental Services Manager will audit the water temperature log to ensure that temperatures are being recorded on a daily basis. 4. The Environmental Services Manager will present the findings of the audits to the QI Committee for a period of 3 months and then quarterly or at the recommendation of the QI Committee.	
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation during the environmental tour, it was determined that the facility failed to provide a safe and sanitary environment for residents and staff. Findings include:	F 465	F465 1. The West Wing bathroom now has an automatic door closer installed, which prevents the door from remaining open. Damaged and missing tiles in the bathroom have been replaced. A new toilet has been installed in the Men's room with the proper caulking at the base. Trash has been removed from behind the ice	8/17/10

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[redacted]	085042	A. BUILDING _____ B. WING _____	C 06/15/2010

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F 465	Continued From page 56 The following observations were made while touring the facility from 6/1/10 through 6/14/10: 1. On 6/1/10, 6/2/10, 6/7/10, West Wing staff bathroom, intended for use by staff and visitors and having no emergency call system was observed with the door open, unlocked and accessible to residents. A label on the door stated, "Keep the door locked at all times". On 6/7/10, in an interview E12 (Environmental Services Manager).confirmed the doors were to be kept locked. 2. The women's bathroom outside the laundry room had a missing ceiling tile. Peeling and discolored caulking around the base of the toilet in the men's bathroom outside of the laundry room was observed. This is a repeat deficiency from last year's annual survey, 1/12/09. 3. Trash was observed in the back of the ice machine in the 600 unit nutrition pantry room. On 6/7/10, trash was observed inside a soiled linen cart in the West Wing central resident bathroom. On 6/7/10, in an interview findings were confirmed by E12.	F 465	machine in the 600 wing. Trash is placed only in receptacles meant for trash. 2. A daily walk through by the Administrator and/or Environmental Services Manager, to include bathrooms outside common areas is conducted daily to ensure proper maintenance is done, all doors are closed as necessary, and that trash is placed in the proper receptacles. 3. An in-service has been conducted by the Safety Chair/ Environmental Services Manager for facility personnel to ensure compliance is met with closing of necessary doors, identifying and recording repairs that need to be completed, and disposing of trash in the proper receptacles. An audit will be conducted by the Administrator and/or Environmental Services Manager to ensure proper maintenance is done, all doors are closed as necessary, and that trash is placed in the proper receptacles to ensure that compliance is met. 4. The Environmental Services Manager will coordinate the findings from the audits and present the findings of the audits to the QI Committee for a period of 3 months and then quarterly or at the recommendation of the QI Committee.	
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was			

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F 467	Continued From page 57 determined that the facility failed to maintain adequate ventilation as reflected by malfunctioning exhaust vents in the facility's soiled utility room, resident bathrooms, chemical closet and laundry room. Findings include: On 6/7/10 during the environmental tour, the exhaust vents in the following areas were not drawing air into the vent: 1. The exhaust vents in the bathrooms of resident rooms 201, 206, 207, 403, 501, 503, and 505. 2. The exhaust vent in the 400 unit soiled utility room. 3. The exhaust vent in the chemical closet in the kitchen. 4. The exhaust vent in the central laundry room washer and soiled linen receiving area. On 6/14/10, in an interview E12 (Environmental Manager) confirmed these findings.	F 467	1. The motor was replaced as well as the belts and pulleys for the ventilation system. The following vents are now in proper operation: Rooms 201, 206, 207, 403, 501, 503, and 505; the exhaust vent in the 400 unit soiled utility room; the exhaust vent in the chemical closet in the kitchen; and the exhaust vent in the central laundry room washer and soiled linen receiving area. 2. Ventilation systems are being checked on a weekly basis along with quarterly inspections for air handler motors, belts and filters. This will ensure that proper ventilation is afforded throughout the facility. 3. An in-service has been conducted by the Environmental Services Manager for Maintenance staff to ensure that motors, belts and filters are checked properly and that a weekly log is retained for checking exhausts in hallways, restrooms, closets, offices and supply rooms. The Environmental Services Manager will review the log each week for compliance and will conduct an additional audit once per month for 6 months. 4. The Environmental Services Manager will present the results of the audits to the QI Committee for a period of 3 months and then quarterly or at the recommendation of the QI Committee.	8/17/10
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;			

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F 514	Continued From page 58 and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain clinical records for 2 (R2 and R199) out of 57 Stage II sampled residents in accordance with accepted professional standards and practices that are readily accessible and systematically organized. Findings include: 1. Review of the active care plan for R2 revealed lack of a care plan for contractures, despite R2 continuing to have contractures. Finding was confirmed with E6 (LPN Unit Manager) during an interview on 6/8/10. On 6/9/10, E3 (MDS Coordinator) provided a copy of R2's contracture care plan that she stated was found in the resident's thinned records. E3 confirmed that the contracture care plan should have been in the active record, not the thinned record. 2. Review of the clinical record for R199 who was admitted to the facility on 4/12/10 and discharged on 4/18/10, revealed that there were no CNA - ADL Tracking forms for each shift on the record. On 6/14/10, in an interview with E2 (DON), she stated that the facility was looking for the CNA forms for R199. She stated that they were looking to see if they were misfiled on another resident's record. On 6/15/10, E2 stated that they located the 4/10 CNA - ADL Tracking forms for 7 AM - 3 PM and 11 PM - 7 AM shifts which were misfiled on another resident's record. However, they were	F 514	1. The Contracture Care Plan for contractures was added to the care plans for Resident R2. This care plan includes monitoring for pain and positioning and seating. Resident R199 no longer resides in the facility. 2. Records are properly maintained to ensure that all pertinent information can be found in the resident's current or closed charts. This has been facilitated through use of a documentation check list for all resident records. 3. An in-service has been conducted by the Administrator/designee for Unit Clerks, licensed personnel and Medical Records Clerk to review the check list, to identify proper thinning of charts, and to identify proper management of documentation for each resident. During Care Plan meetings, a review of Care Plans will be conducted to ensure relevant care plans are present in the resident's record. An audit will be conducted by the Medical records Clerk/designee to ensure proper documentation has been placed in relevant records by 20 records per month for 3 months, than 10 records per month for 3 months. An audit will be conducted by the RNAC/designee to ensure relevant resident issues are care planned, reviewed and revised during quarterly/annual care conferences.	8/17/10

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F 514	Continued From page 59 unable to locate the 4/10 CNA - ADL Tracking form for 3 PM - 11 PM shift. E2 reviewed the CNA - ADL Tracking forms for 7 AM - 3 PM and 11 PM - 7 AM shifts with the surveyor. The form for 7 AM - 3 PM shift was blank for 4/16/10 and the amount of fluids consumed on 4/17/10 by R199 was unreadable for breakfast. The form for 11 PM - 7 AM shift was blank for 4/15/10, 4/16/10, and 4/17/10. The clinical record was not accurate and complete for R199. On 6/15/10, findings were acknowledged by E2 (DON).	F 514	4. The Medical Records Clerk and the RNAC, respectively will present the results of the audits to the QI Committee for a period of 3 months and then quarterly or at the recommendation of the QI Committee.	
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on in-service documentation reviews, facility policies and procedures review, and staff interviews, it was determined that the facility failed to ensure that four (4) of nine sampled staff (E22, E23, E24, E25) were trained in emergency procedures when they began work at the facility or periodically thereafter. Findings include: Review of the facility "in-service Training Program " policy and procedures revealed that the staff development department would provide staff in-service program (orientation of all new employees at time of hire and regular ongoing	F 518		

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F 518	Continued From page 60 in-service training programs). The procedure also revealed that attendance sign-in sheets and individual in-service programs would be provided yearly for each staff member. Facility in-service records were reviewed for three (3) nurses and one (1) CNA as shown below. Documentation of in-service training to validate which staff had training was not available. 1. E23 (RN) hired on 3/12/09 had no emergency preparedness training upon hire or periodically thereafter. 2. E24 (LPN) hired on 9/8/08 had no emergency preparedness training upon hire or periodically thereafter. 3. E25 (LPN) hired on 4/10/06 had no emergency preparedness training upon hire or periodically thereafter. 4. E22 (CNA) hired on 5/1/10 had no emergency preparedness training upon hire. Nursing and certified nursing assistant interviews on 6/7/10 confirmed they were not familiar with what to do in the event of a weather related emergency, missing person, or bomb threat as stated in the facility's Emergency Preparedness procedures. On 6/14/10, in an interview E5 (Staff Development Nurse) and E21 (Human Resource Manager) confirmed these findings.	F 518	1. Employees still with the facility have been in-serviced in emergency preparedness to include what to do in the event of a weather related emergency, missing person, or bomb threat. 2. All new employees and then on an annual basis thereafter will participate in emergency preparedness to include what to do in the event of a weather related emergency, missing person, or bomb threat. 3. An in-service regarding emergency preparedness has been conducted for the identified individuals still employed. The Staff Development Coordinator has developed a check sheet with all mandatory in-services that she will utilize for all new employees. In addition, the Staff Development Coordinator will utilize a check list for annual in-services for all employees. The HR Manager will conduct an audit of all new staff and 25% of staff due annual in-services for 6 months to ensure compliance with completion of the emergency preparedness in-services. 4. The HR Manager will present the results of the audits to the QI Committee for a period of 3 months and then quarterly or at the recommendation of the QI Committee.	8/17/10

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085042	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/15/2010
NAME OF PROVIDER OR SUPPLIER: ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE: 100 ST. CLAIRE DRIVE HOCKESSIN, DE		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 247	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and resident and staff interviews, it was determined that the facility failed to ensure that one (R82) of 57 Stage II sampled residents, received notice before the resident's roommate in the facility was changed. Findings include: The facility's policies and procedures on "In-House Resident Room Transfer" and the "Resident Admission Agreement" were reviewed. The Resident Admission Agreement procedure states that "the resident has the right to receive notice before his or her roommate is changed by the health care center". The In-House Resident Room Transfer Policy and procedure stated that "the social service caseworker or admissions representative will contact the resident and or responsible party to discuss need for room changes and will provide as much advance notice as possible or as required by law. ...The Clinical record will reflect rationale for moves, notification of roommate changes, introductions of new roommates and efforts to ease the transition". R82 was admitted to the facility on 5/15/06. R82's quarterly Minimum Data Set (MDS) assessment, dated 3/20/10, indicated R82 was independent for daily decision making and had no short or long term memory problems. Review of R82's clinical record, including social service notes, lacked evidence that this resident and/or family was given notice before a roommate change on 1/29/10. Interview with R82 on 6/7/10 at 1:35 PM revealed that she had not been informed that a new roommate was moving into her room on 1/29/10. Interview with E26 (Admission Coordinator) on 6/8/10 at 11:22 AM revealed that a new roommate had moved into R82's room on 1/29/10, however there was no evidence that R82 was informed prior to the move.
F 287	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment. Annual assessment updates. Significant change in status assessments. Quarterly review assessments.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085042	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/15/2010
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F 287	Continued From Page 1

A subset of items upon a resident's transfer, reentry, discharge, and death.
Background (face-sheet) information, if there is no admission assessment.

Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following:

Admission assessment.
Annual assessment.
Significant change in status assessment.
Significant correction of prior full assessment.
Significant correction of prior quarterly assessment.
Quarterly review.
A subset of items upon a resident's transfer, reentry, discharge, and death.
Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined that the facility failed to electronically transmit to the State, at least monthly, an MDS assessment for 1 (R24) out of 57 Stage II sampled residents. Findings include:

R24 was admitted to the facility on 4/26/10. Review of R24's clinical record revealed lack of an admission MDS.

On 6/8/10, E4 (MDS Coordinator) provided a copy of R24's admission MDS, dated 5/3/10, that was stored in her office and confirmed that the MDS had not yet been transmitted to the State. The facility failed to transmit R24's admission MDS within 31 days; as of 6/8/10, it was 36 days.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

LTC Residents Protection
JUL 16 2010
Director's Office

STATE SURVEY REPORT

NAME OF FACILITY: St. Francis Care Center at Brackenville

DATE SURVEY COMPLETED: June 15, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility from June 1, 2010 through June 15, 2010. The deficiencies contained in this report are based on observations, staff interviews, review of clinical records, facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was eighty seven (87). The survey sample totaled fifty-seven (57) residents.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby**	

Provider's Signature Michelle Young Title Administrator Date 8/8/10

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: St. Francis Care Center at Brackenville

DATE SURVEY COMPLETED: June 15, 2010

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	adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 6/15/10, F157, F164, F174, F225, F226 (Ex. 2) F241, F247, F253, F272, F278, F279, F280, F287, F309, F312, F314, F318, F323 (Ex.1, 2, 3, 6, & 7), F329, F356, F425, F428, F441 (Ex. 2, 3, 4, 5, 6, 7, &8), F465, F467 (Ex. 3) and F514.	
3201. 6.5	**Food Service**	Please refer to CMS F tags: F157, F164, F174, F225, F226 (ex. 2), F241, F247, F253, F272, F278, F279, F280, F287, F309, F312, F314, F318, F323 (Ex 1,2,3,6 and 7), F329, F356, F425, F428, F441 (Ex 2, 3, 4, 5, 6, 7, 80, f465, f467 (Ex 3) and F514.
3201. 6.5.1	**Meals** **Therapeutic diets, mechanical alterations and changes in either must be prescribed by an attending physician within 72 hours of implementation. All meals and snacks shall be served in accordance with the therapeutic diet, if prescribed.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 6/15/10, F365.	Please refer to F365

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3201. 6.8.2	**Medication Storage and Stocks**	
3201. 6.8.2.2	**All medications shall be stored in a locked cabinet. The key to the cabinet shall be kept in the control of the licensed nurse responsible for the administration of medications.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 6/15/10, F323 (Ex. 4 & 5).	Please refer to F323 (Ex 4 and 5)
3201. 6.10	**Infection Control**	
3201. 6.10.1	**Infection Control Committee**	
3201. 6.10.1.5	**The infection control coordinator shall maintain records of all nosocomial infections and corrective actions related to those infections to enable the committee to analyze clusters or significant increases in the rate of infection and to make recommendations for the prevention and control of additional cases.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 6/15/10, F441 (Ex. 1).	Please refer to F441 (Ex.1)

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3201. 7.0	**Plant, Equipment and Physical Environment**	
3201. 7.4.3	**Bathrooms**	
3201. 7.4.3.1	**Bathroom walls and floors shall be impervious to water. Bathrooms shall have at least one window or mechanical ventilation exhausted to the outside.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 6/15/10, F467 (Ex. 1).	Please refer to F467 (Ex. 1)
3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** **This requirement is not met as evidenced by:** Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 3-501.16 (A), 4-203.12 (B), 4.602.13, and 5-501.115 of the State of Delaware Food Code. Findings include: **3-501.16 Potentially Hazardous Food, Hot and Cold Holding*** **Except during preparation, cooking, or cooling,**	

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	or when time is used as the public health control as specified under § 3-501.19, potentially hazardous food shall be maintained: **(A) At 60°C (140°F) or above, except that roasts cooked to a temperature and for a time specified under ¶ 3-401.11 (B) or reheated as specified in ¶ 3-403.11 (E) may be held at a temperature of 54°C (130°F).** Cross refer to CMS 2567-L, survey completed 6/15/10, F371, example #1. **4-203.12 Temperature Measuring Devices, Ambient Air and Water.** **(B) Ambient air and water temperature measuring devices that are scaled in only in Fahrenheit shall be accurate to +/- 3°F in the intended range of use.** Cross refer to CMS 2567-L, survey completed 6/15/10, F371, examples #3 and #4 **4-602.13 Nonfood-Contact Surfaces.** **Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.**	Please refer to F371, ex 1 Please refer to F371 ex. 3 and 4

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	Cross refer to CMS 2567-L, survey completed 6/15/10, F371, example #2.	Please refer to F371, Ex 2
	5-501.115 Maintaining Refuse Areas and Enclosures.	
	A storage area and enclosure for refuse, recyclables, or returnables shall be maintained free of unnecessary items, as specified under § 6-501.114, and clean.	
	Cross refer to CMS 2567-L, survey completed 6/15/10, F372.	Please refer to F372
3201. 7.6	**Sanitation and Laundry**	
3201. 7.6.3.1	**Provide a room under negative air pressure for receiving, sorting, and washing soiled linen.**	
	This requirement is not met as evidenced by:	
	Cross refer to CMS 2567-L, survey completed 6/15/10, F467 (Ex. 4).	Please refer to F467 (ex. 4)
3201. 7.6.3.1.1	**If hot water is used for destroying micro-organisms, washers must be supplied with water heated to a minimum of 160° F.**	

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	This requirement is not met as evidenced by: Cross refer to CMS 2567-L, survey completed 6/15/10, F456.	Please refer to F456.
3201. 7.6.5	**The facility shall have a soiled utility room under negative pressure for storage of infectious waste and for disposal of body fluids. The room shall have a work counter, hand washing sink, and clinical sink or other bed pan cleaning device.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 6/15/10, F467 (Ex. 2).	Please refer to F467 (ex. 2)
3201. 8.0	**Emergency Preparedness**	
3201. 8.4	**The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 6/15/10, F518.	Please refer to F518

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16 Del. C., Subchapter IV, §1141 (c)	**Criminal background checks.** **No employer who operates a nursing home or a management company or other business entity that contracts to operate a nursing home may hire or employ any applicant without obtaining a report of the person's entire criminal history record from the State Bureau of Identification and a report from DHSS regarding its review of a report of the person's entire federal criminal history record pursuant to the Federal Bureau of Investigation appropriation of Title II of Public Law 92-544.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 6/15/10, F226 (Ex. 1).	Please refer to F226

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